The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call a Benefit Advocate at (888) 920-7526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary.com or call 888-920-7526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,000 / Individual or $6,000 / family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-Network Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,500 / Individual or $13,000 / Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments on certain services, premiums, balance billing charges, services not covered by this plan, fees above RBP rates and/or UCR rates.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See the MultiPlan website or call 866-981-7427 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. **This plan uses *MultiPlan's PHCS Specific Services* Network.**
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.
Copayment for office visits apply to visits only. In-office procedures may not be covered.
Out-of-Network care is covered at 150% of Medicare reimbursement rates (RBP). In the absence of a Medicare rate the plan will pay UCR.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/office visit	$35 copay/office visit	In-office procedures may be excluded.
	Specialist visit	$60 copay/office visit	$60 copay/office visit	In-office procedures may be excluded.
	Preventive care/screening/ immunization	No Charge	No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, then check what your plan will pay for. **If you receive a bill for preventive services, call a Benefit Advocate at (888) 920-7526.**
If you have a test	Diagnostic test (x-ray, blood work)	$10 copay/test	$10 copay/test	No Coverage for X-rays. Copayments apply to lab work (e.g. blood work) per test, not per draw.
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	No Coverage for Diagnostic Radiology and Imaging.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at OptumRx.com	Generic drugs	Not Covered*	Not Covered	Prescription discounts may be available. Check OptumRx.com for more information.
	Preferred brand drugs	Not Covered*	Not Covered	
	Non-preferred brand drugs	Not Covered*	Not Covered	
	Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	No coverage for Surgical care.
	Physician/surgeon fees	Not Covered	Not Covered	No coverage for Surgical care.
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	No Coverage for Emergency room care.
	Emergency medical transportation	Not Covered	Not Covered	No Coverage for Emergency medical transportation.
	Urgent care	Not Covered	Not Covered	No Coverage for Urgent Care services.

* For more information about limitations and exceptions, see the plan or policy document at https://helpdesk.planstin.com/benefit-information

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	No Coverage for Inpatient care.
	Physician/surgeon fees	Not Covered	Not Covered	No Coverage for Inpatient care.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	No Coverage for Outpatient care.
	Inpatient services	Not Covered	Not Covered	No Coverage for Inpatient care.
If you are pregnant	Office visits	$60 copay/visit	$60 copay/visit	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment or deductible may apply. Out-of-Network visits are covered at 150% of Medicare reimbursement rates.
	Childbirth/delivery professional services	Not Covered	Not Covered	No Coverage for Childbirth and delivery services.
	Childbirth/delivery facility services	Not Covered	Not Covered	No Coverage for Childbirth and delivery services at any facility.
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	No Coverage for private-duty nursing, home health aides, respite, custodial, supportive, or rest care.
	Rehabilitation services	Not Covered	Not Covered	No Coverage for Rehabilitation services.
	Habilitation services	Not Covered	Not Covered	No Coverage for Habilitation services.
	Skilled nursing care	Not Covered	Not Covered	No Coverage for Skilled nursing care.
	Durable medical equipment	Not Covered	Not Covered	No Coverage for Medical equipment.
	Hospice services	Not Covered	Not Covered	No Coverage for Hospice services.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	No Coverage for vision care, except as otherwise covered in Section VI of the Summary Plan Description.
	Children's glasses	Not Covered	Not Covered	Contacts, lenses, and frames are excluded.
	Children's dental check-up	No Charge	No charge	No Coverage for dental care, except as otherwise covered in Section VI of the Summary Plan Description.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Allergy Services
- Asthma Treatment, therapeutic
- Bariatric Surgery
- Cancer-related therapies
- Chiropractic care
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty Nursing
- Psychiatric Services
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

Both in- and out-of-network cost-sharing amounts will be applied to the deductible and out-of-pocket max, limited to RBP/UCR rates only. Any balance billing charges or charges for services not covered under this health plan will not be applied to the deductible or out-of-pocket maximums.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor, Employee Benefits Security Administration, 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor, Employee Benefits Security Administration, 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **No**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al (888) 920-7526.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (888) 920-7526.

[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 (888) 920-7526.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (888) 920-7526.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$3,000**
Specialist visit copayment	**$60**
Hospital (facility) coinsurance	**none**
Other coinsurance	**none**

This EXAMPLE event includes services like:
Specialist Office Visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic Tests (ultrasounds and blood work)
Specialist Visit (anesthesia)

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$360
Coinsurance	$0
What isn't covered	
Limits or exclusions	$9,440
The total Peg would pay is	**$12,800**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$3,000**
Specialist visit copayment	**$60**
Hospital (facility) coinsurance	**none**
Other coinsurance	**none**

This EXAMPLE event includes services like:
Primary Care Physician Office Visits (including disease education)
Diagnostic Tests (blood work)
Prescription Drugs
Durable Medical Equipment (glucose meter)

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$1,440
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,960
The total Joe would pay is	**$7,400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$3,000**
Specialist visit copayment	**$60**
Hospital (facility) coinsurance	**none**
Other coinsurance	**none**

This EXAMPLE event includes services like:
Emergency Room Care (including medical supplies)
Diagnostic Test (x-ray)
Durable Medical Equipment (crutches)
Rehabilitation Services (physical therapy)

Total Example Cost	**$2,500**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

The plan would be responsible for the other costs of these EXAMPLE covered services.